INTAKE/REFERRAL FORM
Rising Phoenix Health and Wellness
Empowerment Center, LLC.
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404-395-2005
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REFERRAL SOURCE INFORMATION:

Date of Referral:	
Name and title of person making referral:	
Agency/Organization:	
Phone number:	
Email address:	
Are monthly reports needed once services begin? ***(Note: Release of Information Required)***	☐ **YES** ☐ **NO** **If YES, please provide receiving email address:**_____
Is the client mandated to participate in services?	☐ **YES** ☐ **NO**

CLIENT INFORMATION:

Client's Name:				**Date of Birth:**			
Age:		**Gender:**		**Race**			
Address:		**City:**		**State:**		**Zip**:	
Phone Number:		**Email Address:**					
Insurance Type:		**Policy Holder Name:**		**Policy #**			
Parent/Guardian Name:							
Parent/Guardian Phone Number(s):							
Parent/Guardian Email Address:							

SERVICE(S) REQUESTED:

☐ Individual Therapy ☐ Family Therapy ☐ Group Therapy ☐ Skills Building ☐ Psychiatric Services ☐ Other:_____

PRESENTING PROBLEM:

☐ ADHD ☐ Anxiety ☐ Behavioral Regulation ☐ Defiance ☐ Depression ☐ DFCS Involvement ☐ DJJ Involvement ☐ Substance Use Disorder
☐ Family Conflict ☐ Grief ☐ History of Abuse/Trauma ☐ History of Counseling ☐ Life Changes ☐ Stress Management
☐ Other:
Brief description of presenting problem:

ADMINISTRATIVE USE ONLY:

Referral received by:		**Date received:**	
Date processed:		**Date of initial contact:**	
Meets requirements for services:		**Initial appointment scheduled for:**	
Other notes:			